



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

PINE CREEK MEDICAL CTR  
9032 HARRY HINES BLVD  
DALLAS TX 75235-1720

#### **Respondent Name**

AMERICAN CASUALTY CO OF READING PA

#### **Carrier's Austin Representative Box**

Box Number 47

#### **MFDR Tracking Number**

M4-10-1196-01

#### **MFDR Date Received**

October 21, 2009

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Since the carrier was not in compliance with the AETNA Contract. I am requesting that this bill be paid in accordance with the Fee Schedule guidelines since they are implementing the fee schedule rules and regulations."

**Amount in Dispute:** \$10,803.77

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Carrier processed payment @ 200%reimbursement Rate PPO discount then taken provider Did not request separate Reimbursement for implants please see attached As billing processed @ 200% - no allowable for implants."

**Response Submitted by:** Specialty Risk Services, 300 S. State St., Syracuse, NY 13202

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2009	Outpatient Hospital Services	\$10,803.77	\$10,803.77

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.4 requires written notification to health care providers of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. Texas Labor Code §413.011(d-3) specifies the contract information that shall be provided on Division request.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE FOCUS/AETNA WORKERS COMP ACCESS LLC CONTRACT. FOR QUESTIONS REGARDING NETWORK REDUCTIONS. PLEASE CALL 1-800-243-2336.
  - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. MAR AMOUNT IS GREATER THEN THE CHARGED AS PER TEXAS HOSPITAL GUIDELINES.
  - 217 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT. REDUCED TO FAIR AND REASONABLE.
  - W1 – WC STATE FEE SCHEDULE ADJUSTMENT. PACKAGED SERVICES ARE INCLUDED IN THE APC RATE.

### **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. The insurance carrier reduced or denied disputed services with reason code 45 – “CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE FOCUS/AETNA WORKERS COMP ACCESS LLC CONTRACT. FOR QUESTIONS REGARDING NETWORK REDUCTIONS. PLEASE CALL 1-800-243-2336.” While both parties allege that there is a contractual relationship between the parties, review of the submitted information found insufficient evidence to support that the services in dispute are subject to a contracted fee arrangement. 28 Texas Administrative Code §133.307(e)(1) states that “The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available.” Texas Labor Code §413.011(d-3) requires, in pertinent part, that “An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . For medical fee disputes that arise regarding non-network and out-of-network care, the division may request that copies of each contract under which fees are being paid be submitted to the division for review.” On January 11, 2011, the Division requested the respondent to provide a copy of the referenced network contract and documentation to support provider notification as required under 28 Texas Administrative Code §133.4. The respondent did not submit copies of the requested information. The above denial/reduction reason is not supported. Pursuant to Texas Labor Code §413.011(d-3), which states, in pertinent part, that “the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: (1) is not provided in a timely manner to the division on the division's request,” the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted bill finds that the remarks field in the lower left corner of the bill states “REQ 200% REIMBURSEMENT.” The Division therefore concludes that separate reimbursement of implantables was not requested. The applicable rule for determining reimbursement is §134.403(f)(1).
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,950.67. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$1,914.78. The non-labor related portion is 40% of the APC rate or \$1,300.44. The sum of the labor and non-labor related amounts is \$3,215.22. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.24. This ratio multiplied by the billed charge of \$6,500.00 yields a cost of \$1,560.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$3,215.22 divided by the sum of all APC payments is 42.81%. The sum of all packaged costs is \$4,659.79. The allocated portion of packaged costs is \$1,994.84. This amount added to the service cost yields a total cost of \$3,554.84. The cost of this service exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is \$3,215.22. This amount multiplied by 200% yields a MAR of \$6,430.44.
- Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,950.67. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$1,914.78. The non-labor related portion is 40% of the APC rate or \$1,300.44. The sum of the labor and non-labor related amounts is \$3,215.22. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,607.61. This amount multiplied by 200% yields a MAR of \$3,215.22.
- Procedure code 29821 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,950.67. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$1,914.78. The non-labor related portion is 40% of the APC rate or \$1,300.44. The sum of the labor and non-labor related amounts is \$3,215.22. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,607.61. This amount multiplied by 200% yields a MAR of \$3,215.22.
- Per Medicare policy, procedure code 29822 is included in, or mutually exclusive to, another code billed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 29822 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$1,943.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,165.87. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$1,144.42. The non-labor related portion is 40% of the APC rate or \$777.25. The sum of the labor and non-labor related amounts is \$1,921.67. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$960.84. This amount multiplied by 200% yields a MAR of \$1,921.68.
- Per Medicare policy, procedure code 64415 is included in, or mutually exclusive to, another code billed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 64415 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0206, which, per OPPS Addendum A, has a payment rate of \$241.11. This amount multiplied by 60% yields an unadjusted labor-related amount of \$144.67. This

amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$142.01. The non-labor related portion is 40% of the APC rate or \$96.44. The sum of the labor and non-labor related amounts is \$238.45. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$119.23. This amount multiplied by 200% yields a MAR of \$238.46.

- Procedure code 76001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
4. The total recommended payment for the services in dispute is \$15,021.02. This amount less the amount previously paid by the insurance carrier of \$1,883.50 leaves an amount due to the requestor of \$13,137.52. The requestor is seeking \$10,803.77. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. Pursuant to Texas Labor Code §413.011(d-3), the insurance carrier may be required to pay fees in accordance with the Division's fee guidelines if the contract is not provided in a timely manner to the Division on the Division's request. The respondent failed to provide a copy of the alleged contract in response to a Division request; therefore, the respondent is ordered to pay fees in accordance with the Division's fee guidelines in the amount of \$10,803.77.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$10,803.77, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	Grayson Richardson	September 7, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service* demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**